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"ON LANGUAGES"

EVER since the curse of God fell upon the tower of Babel, converting its aspiring builders into an unintelligible rabble, the lack of a universal tongue has nullified the efforts of man to achieve a stable world—for understanding is the first demand of friendship. In the middle ages this diversity of speech was of little consequence, for then the scholar, always in a great minority, did in fact possess a medium of common exchange in the form of Latin, however adulterated it may have been, whereby he could exchange his views and knowledge in the certainty of being understood by his contemporaries in other lands. For the mass of the people, however, who existed in small and closed communities the need for such intercourse did not arise since they placed no reliance upon, nor indeed saw the need of, co-operation between such communities. Such a limited state of affairs, however, could not last and with the growth of civilisation as we know it today, the inevitable demand for closer co-operation has brought with it an ever more insistent demand for understanding. This demand, however, has not been answered; the continually widening scope of society has carried in its wake intolerance and confusion, the barrier of language has always proved too great for our ineffectual strivings.

In the muddle which constitutes international relations of today the need for exchange of ideals and principles is of paramount importance, and this is true also in every branch of learning and knowledge. The lack of international exchange which exists in the medical world today is due not to any desire of medical society to remain isolated from contemporary thought in other parts of the world, but rather to the inability of its members either to read or write in any tongue but their own. The advantage which the scholar of the Middle Ages possessed in having at his disposal a language in which he could express his feeling to his fellows of similar status is lost to us. True it is that to some extent the nomenclature of the various sciences is based upon a common principle, but this does little to relieve the gloom which hides not only the knowledge and dissemination of contemporary medicine, but also the very customs and philosophies of one people from another. In the past history of education, Latin or Greek were, because of their universal application, a *sine qua non* in the curriculum of school and university. Unfortunately the complexity of our present society, and the diversity of its demands upon us, have left but little time for acquiring or receiving any similar course of instruction; it is being increasingly left to the individual industry of the pupil, a factor of naturally small proportions in a schoolboy, to acquire a working knowledge of any language but his own and even this, in many schools, is taught with but doubtful competence.

It is a fact that only after leaving school does one begin to appreciate how important is education and how great were the chances missed; but by then the average individual is in no position to return to his studies in order to fill the gaps in his knowledge. An article recently published in the B.M.J. entitled '*Languages in the services of Modern Medicine*,' quotes a passage mentioned by Lock in his "*Some thoughts concerning Education*." "One can scarce burden children too much with the knowledge of Languages," it reads, and a little further on,

"They are useful to men of all conditions." It continues to impress upon the reader that the only time to teach such a subject is during youth, when " . . . those on whom the child depends have Authority enough to keep him close to a long continued Application." On reflection, therefore, it is indeed depressing that with necessity of languages in the dissemination of knowledge, so little attention is paid to the teaching and learning of these subjects in the medical schools of this country. True enough the medical student is more than overburdened by the quantity of knowledge which he is expected to possess on qualifying, but at the same time there must exist some scope for the teaching of languages in such establishments. The value of French and German both as keys to medical literature and as aid to the study of other languages is emphasised by the article mentioned earlier. It is true that in this respect the overwhelming predominance of English as a language throughout the world does, to some extent, supply the want of a common tongue. This, however, is but a one way service, for as a result of the well-known inability of the English speaking nations to learn any language but their own, such literature as is published in a foreign tongue remains virtually a closed book unless an intermediate can be found to act as interpreter. In itself the need for such a provision constitutes a considerable obstacle, for such information is by definition second hand and thereby depends upon the ability and discretion of the interpreter—an unsatisfactory, though unavoidable, condition.

The author of the article, in making a careful analysis of foreign journals which are available to the reader in the Manchester Medical Library, shows that no Journals in German, Spanish or Portuguese are indexed though certainly the latter two possess today a flourishing medical literature; our own library lists none. This sparsity of foreign literature is due not to inadequate library policies but rather to the woefully small demand created by the users of such libraries; a sad reflection on the linguistic accomplishments of the medical community. In America the pre-clinical training of a student includes, in the curriculum, the compulsory study of at least two languages. This, however, is not to advocate the adoption of a similar regime in this country where the pre-medical training period should supply the need in this direction but it does show that the American medical schools do appreciate the important place which such a study holds in the world-wide spread of medical knowledge.

Before the war voluntary German classes were held in this hospital for any student who wished to attend and occasionally lectures were given on the same subject. The resumption of such a practice cannot be too strongly advocated.

It has been suggested that the Brackenbury Scholarship should include a paper in either French or German, and in the opinion of this Journal such a step should be taken, with the provision, however, that such a paper should be of a voluntary nature though at the same time bearing weight with the examiner in the final result. The Brackenbury Scholar is eminently one on whom the future of Medicine might be expected to depend; surely then it is not unreasonable to ask that he should be able to maintain himself with his contemporaries overseas?

ABERNETHIAN SOCIETY

April 28th—Professor A. C. Frazer, M.D., D.Sc., M.R.C.P. "Problems of normal and abnormal fat absorption in man."

ELEVENTH DECENNIAL CLUB

The next meeting of the Eleventh Decennial Club will be held at Frascati's Restaurant, Oxford Street, on Friday, May 6th, at 7.0 for 7.30 p.m. Dr. E. B. Brooke will be in the Chair. Details can be obtained from the Hon. Secretary, Wilfred Shaw, 109, Harley Street, W.1.

HEAT STROKE IN IRAK

By W. V. CRUDEN, M.B., B.S.

THERE was more than one problem that faced Adam and Eve in the Garden of Eden. For they were living, according to tradition, in one of the hottest spots in the world — Southern Mesopotamia—where the tent temperature sometimes reaches 135° F. and where the problem of the regulation of body heat is at its acutest.

Ever since the Mongol invasion the country has been a huge expanse of brown mud — dry and hot in the summer, paralysingly sticky and squelchy in the winter rains. "Mespot" has indeed been aptly described by a British Tommy as "miles and miles and miles of d . . . all"! It is in this country that Heat Exhaustion and Heat Stroke are a perpetual menace.

In earlier days, before the country became a desert, the heat may not have been as intense as it is now, but there is plenty of evidence to show that even then it was a very hot spot, and "the shadow of a great rock in a weary land" symbolises the immense value placed upon any shelter from the sun's rays. The native Iraqi of to-day knows the sun for what it is—man's greatest enemy, and he realises that a drink of water can be the most precious experience of the day. He occupies the heated mid-day hours with the siesta—that cessation of work and period of repose which the British soldier nicknamed "Egyptian P.T." If he has to move he ambles about slowly, keeping instinctively in the shade whenever possible. It is probable, too, that his flowing robes have some effect in diminishing the danger of excessive heat.

The European, on the other hand, has not this age-long knowledge of tropical heat and cannot easily adapt himself to it. "Mad dogs and Englishmen lie out in the mid-day sun." British troops in two world wars learnt at heavy cost of the dangers of the climate. The summer of 1917 was exceptionally hot and there were some 9,000 heat casualties in our troops. In the last war there were fewer cases because the danger was better known and understood, but even so there were many deaths and much suffering especially amongst unacclimatised troops.

One cannot better describe the terrific despotism of the sun in these lands than by quoting a few sentences from Doughty's "Arabia Deserta."

". . . The summer's night at end, the sun stands up as a crown of hostile flames from that huge covert of inhospitable bergs; the desert day dawns not little and little, but it is noontide in an hour. The sun, entering as a tyrant upon the waste landscape, darts upon us a torment of fiery beams, not to be remitted till the far-off evening. No matins here of birds; not a rock partridge-cock, calling with blithesome chuckle over the extreme waterless desolation. Grave is that giddy heat upon the crown of the head; the ears tingle with a flickering shrillness, a subtle crepitation it seems, in the glassiness of this sun-stricken nature: the hot sand-blink is in the eyes, and there is little refreshment to find in the tents' shelter; the worsted booths leak to this fiery rain of sunny light . . . This silent air burning about us, we endure breathless till the assr (mid-afternoon) when the dazing Arabs in the tents revive after their heavy hours. The lingering day draws down to the sun-setting: the herdsmen, weary of the sun, come again with the cattle, to taste in their menzils the first sweetness of mirth and repose. The day is done, and there rises the nightly freshness of this purest mountain air: and then to the cheerful song and the cup at the common fire. The moon rises ruddy from that solemn obscurity of jebel like a mighty beacon: and the morrow will be as this day, days deadly drowned in the sun of the summer wilderness."

No wonder, indeed, that Hell is hot to the Semite!

How is the body temperature regulated in these tropical conditions? How is it kept down to 98° F. when the air around is 135°F.? Let us examine the normal mechanism of control, which is perhaps directed by a thermostatic centre in the hypothalamus. Temperature regulation is a balance between heat production on the one hand, and heat loss on the other, and we must consider each of these factors in turn.

First, as regards heat production, heat is necessarily produced in the body as the result of every basal metabolic process. The slightest activity raises the metabolism and therefore the body heat—such a simple act as moving about a room will raise metabolism 20%; eating raises it another 10%; moderate work raises it still more, whilst violent exercise may increase metabolism 16 times above its basal rate. Over activity of thyroid and adrenal glands increases metabolism; this effect is also produced by febrile illnesses—for instance Pneumonia with a body T 105° F. causes no less than a 50% rise in body metabolism; and this of course will, like a vicious circle, tend still further to raise the body temperature. Thus the body, like an internal combustion engine, is itself

perpetually generating a varying amount of heat. This is clearly a good thing in cold climates where our problem is that of keeping the body sufficiently warm. But when the outside air is extremely hot, as it is in Iraq, this internally generated body heat is greatly increased by the hot external air which surrounds it like a Turkish bath, and the combined effects of internal and external heat produce the danger of the person being cooked, alive—or dead. In such circumstances the problem of controlling the body temperature is literally a matter of life and death. How is such a miracle accomplished?

In order to understand this we have to study the second factor in temperature control, namely heat loss. In temperate climates this occurs through conduction, convexion, radiation and evaporation, but when the outside air temperature is higher than the body temperature, the first three of these —conduction, convexion and radiation—are abolished . . . and indeed they are reversed. So that the sole means left to bring about heat loss is evaporation, and a man's life indeed depends upon his sweat glands.

The balance of heat production and heat loss, as we said, is all important. Heat makes a man tired. He therefore works less. It dulls his appetite and he therefore eats less . . . and both these effects lower his metabolism and therefore his heat production. On the other hand the atmosphere stimulates the temperature sense organs in the skin, the skin vascularity is reflexly increased and the sweat glands are urged to greater activity. The insensible sweat is reinforced by sensible sweat, and how "sensible" that sweat is, only those who have lived in a perpetual and all enveloping bath of perspiration, can know. The effect, of course, of this severe sweating with its loss of water and salt, is to make one extremely thirsty. Moreover, the loss of fluid produces a marked concentration and scantiness of urine (with the consequent dangers of crystaluria and calculus formation) and the stools become hard, dry and constipated. Finally the loss of salt, which tends to form a thin crust over the skin and which can sometimes be seen with the naked eye and easily tasted by licking oneself, tends, to produce cramps. (I wonder whether this phenomenon had anything to do with the fate of Lot's wife?)

With all these factors at work it is obvious that there may be many causes for the breakdown of the body's heat regulation mechanism. In a hot climate any form of excessive heat production by the body, be it overwork, overeating, alcoholism or hyperthyroidism will tend to upset the body's equilibrium. Particularly is this the case with febrile infections which are so rife in these parts — (malaria, dysentery and sandfly fever, for instance). Obviously fatigue, starvation and unnecessary exposure to the sun are dangerous. On the other hand, heat loss by evaporation may be upset by many factors; humid atmospheres, tight clothing, or the covering of large areas of the body with bandages or ointments, will obviously interfere with its function. If the sweat glands are defective from congenital anhydrosis, atropine paralysis or extensive skin disease, (such as an acute exfoliative dermatitis) body temperature cannot be controlled and heat stroke is likely. We may, in these cases, attempt to replace the deficient sweat by covering the body with water or wet clothes and allowing this substitute for sweat to evaporate and cool the skin, but we must, of course, perpetually renew our water covering for anything but the most transient relief. Finally this tremendous loss of body fluid, unless replaced by copious drinks of saline water, leads to the dangers of dehydration, haemoconcentration, altered body chemistry and cramps. In such climates 8 pints daily is the minimum intake and as much as 20 pints may be necessary for comfort.

These notes are based on experiences in Iraq in the summer of 1942 and attendance at a Heat Stroke course in Baghdad in 1943. I was stationed near Basrah in the summer of 1942 and during July, August and September, when PAIFORCE was being built up, troopships packed with men were steaming up the sultry Persian Gulf and disembarking hosts of troops in this strategic port. Naturally there were many heat casualties from these ships. Non-acclimatisation, overcrowding and sea-sickness in the Persian Gulf—which is one of the hottest waterways in the world—all played their part. Here is a typical story . . . During the voyage to Iraq there was much seasickness in a monsoon. The cooks also were sick and there was a disorganisation of feeding arrangements and no extra salt issue. The intense heat and high humidity in the Persian Gulf had their effect. The ship docked in the evening—the men remained between decks till 4 a.m. then marched to the railway station and entrained in goods waggons. On arrival

at the Camp area they had to draw and pitch their own tents having had no food since the previous day. One unit, supposed to be self-contained, landed without cookers or rations. There were 100 cases of Effects of Heat, with 12 deaths.

There is only space to describe three distinct syndromes—*Heat Exhaustion; The Subacute Effects of Heat* and *Acute Heat Stroke*. Of course, mixed types and gradations of symptoms occur, but it is as well to describe the three well defined groups.

Heat Exhaustion is the commonest syndrome, and it is usually not serious. Its outstanding feature is circulatory failure or shock. The patient complains of weakness, headache, nausea, giddiness and staggering which may culminate in a faint. The temperature may be raised at the onset but is usually normal or subnormal. The skin is pale and clammy, the pupils dilated, the pulse weak and rapid and the blood pressure low. Urinary chlorides are reduced and cramps may occur. The patient, however, remains rational and the prognosis is good. One must distinguish the condition from algid malaria, seasickness, hypoglycaemia and even fright. Treatment is that of shock, with copious drinks, and salt is given until the urinary chlorides become normal. Even if the temperature is subnormal, the patients should remain in an artificially cooled atmosphere and be carefully watched lest they go on to the heat stage. So much, in brief, for Heat Exhaustion. It was a condition which commonly recurred in susceptible patients. I remember one man who had about 7 attacks and was finally evacuated out of the Country.

The second syndrome has been called *the Subacute Effects of Heat*. It is a serious illness, for the onset is insidious, and an increasing derangement of body chemistry occurs in an apyrexial stage which lasts a week (or even as long as three weeks), and it culminates, if untreated, in the final catastrophe of hyperpyrexia and death. At onset the commonest complaints are lassitude and headache. Digestive upsets occur and particularly important are the mental symptoms. These include insomnia, dullness, irritability, restlessness and a disrespectful and insubordinate attitude to those in authority. Cramps, twitching and frequency of micturition occur. An indication that all is not well with the heat regulating mechanism may be shown by a slight mid-day rise of the otherwise normal or subnormal temperature to 99° or 100°. Now at this stage rest in a cool place may abate the symptoms, but they recur on re-exposure to heat. Anyway, with or without remission, the patient's condition steadily deteriorates. Persistent vomiting and falling blood pressure are bad signs. Dehydration and haemoconcentration occur, the blood urea rises, and the scanty urine may contain albumen, casts and acetone: it is deficient in chlorides. All these are signs of gross upset of body chemistry. Finally the temperature begins to rise and the extremely dangerous Pyrexial stage is at hand. It is often ushered in by increased mental symptoms which may be maniacal in severity. The temperature shoots up rapidly to 105°, 109°, 112° and coma sets in. The picture now is truly terrible. The skin is hot, dry, gritty and inelastic; the face sunken, and the coma is often accompanied by pareses. A terminal circulatory failure and bronchopneumonia occur. As in cholera, rigor mortis is immediate. The chief findings at post mortem are widespread venous engorgement and minute haemorrhages in all organs, and oedema is marked in all cases.

This final phase of hyperpyrexia is more difficult to treat than the pyrexia of acute Heat Stroke (which has yet to be described) for it has been preceded by a long illness which has already gravely disturbed the body chemistry before the final onset of hyperpyrexia. The diagnosis, too, in all stages of the illness, is difficult, especially if the effects of heat are not uppermost in one's mind. For instance, the early mental symptoms may be mistaken for what the Army terms "b-mindedness" and the poor unfortunate finds himself incarcerated in the guard room or mental ward, or worse still punished with fatigue duties (which are surely guaranteed to produce the maximum amount of harm in the minimum amount of time). Again, during the early stages all sorts of diagnoses are possible, and whilst investigations for malaria and dysentery, for meningitis and for that well-known character the "P.U.O." are proceeding in Hospital, valuable time may be lost. Perhaps the greatest difficulties are encountered when heat effects complicate other diseases, and it not infrequently happens that the findings of malarial parasites in the blood is considered the whole story when in reality the major trouble is heat effects. It is in these later cases — Heat Effects plus acute infections—that the prognosis is at its gravest.

The third Syndrome to be described is *Acute Heat Stroke*—a sudden and dramatic failure of the heat regulating mechanism. There may perhaps be mild prodromal symptoms (like those previously described) for a day or two, and there is usually suppression of sweating, but very frequently the attack comes "out of the blue" and the patient whilst at work is smitten unconscious, with hyperpyrexia. This fearful tragedy must have been in the Psalmist's mind when he wrote . . . "the sun shall not smite thee by day," and when Isaiah says "neither shall the heat nor sun smite them." There is, moreover the following pathetic little story in 2 Kings 4, which is considered by the pundits to be a description of acute heat stroke: ". . . And when the child was grown, it fell on a day that he went out to his father to the reapers. And he said unto his father, my head, my head. And he said to a lad, carry him to his mother. And when he had taken him and brought him to his mother, he sat on her knees till noon, and then died . . ."

This acute heat stroke resembles acute alcoholism. The face is congested, the eyes suffused, the pulse full and bounding, the respirations stertorous, and the patient is delirious, stuporose, or in coma. There is, however, one pathognomic sign—the skin is so hot to the touch that one instinctively removes one's hand from the patient's body. The rectal temperature registers anything up to 112° — and even 115° has been recorded before death. Recovery from a temperature of 112° has been seen twice in Iraq when treatment was immediate. Thus hyperpyrexia is obviously a first-class medical emergency. Any delay in cooling is dangerous. I well remember one tall young fellow in Basrah who was admitted with a T 110° and was comatose, or semi-comatose, for two days. He recovered eventually, but he was a pathetic sight, shuffling about the ward with the mentality of a small child. He had been "cooked" too long!

Diagnosis is easier than in the Subacute type though any severe acute fever may simulate the condition. Perhaps one should especially mention meningitis, apical pneumonia, sandfly fever, fulminating typhoid and typhus, and cerebral haemorrhage. The chief problem, of course, is *cerebral malaria*, and if in doubt the patient is treated as having both diseases, with heat stroke as the first priority. Cooling, therefore, is commenced as soon as the thermometer emerges from the patient's rectum, and continues whilst the first blood smear and intravenous quinine are effected. These two conditions are uppermost in one's mind in hyperpyrexial states.

There is only space for a few final words on treatment. Obviously prophylaxis is all important, and education, especially of the unacclimatised, is necessary. The avoidance of over-exposure and overwork during the mid-day heat is important. Suitable clothing should be provided. Most important is a plentiful water supply, preferably kept cool in chaguls or Persian Hubs and with a daily salt ration. Alcohol should be reserved for the cooler evening. There should be a careful vetting of personnel, and those unsuited to the climate—the poor sweaters, the hyperthyroids and the chronically ill, should be removed to more temperate climes.

Prodromal signs of Heat Effects should be noted and severe illness can often be prevented by timely rest in a cool atmosphere. Various methods for artificially cooling the air were devised—one of the most successful being the camel-thorn cooler. In this, camel-thorn was packed very lightly in a suitable wooden frame and water was allowed to trickle over it. By placing the frame at right angles to the prevailing wind the air was cooled as it passed through the camel-thorn, and with a suitable exit for the air at the other end a temperature of 70° could be expected under favourable circumstances.

When removal to Hospital was necessary it was sometimes wiser to delay the journey till the cool of the evening, for the interior of the ambulances became like a furnace at mid-day. In 1943 in Iraq ambulances were being furnished with Cuss-Cuss-tatis (where the air passed through a stream of water before reaching the patient). But it was sometimes advisable when travelling with the wind to turn back on one's tracks and go away from the Hospital for a time to allow the breeze to blow through the Cuss-Cuss-tati and so provide intervals of cooling for the interior of the vehicle.

On reaching Hospital the cases were admitted immediately to the Cooled Heat-Stroke Centre, and hyperpyrexia was at once reduced by spraying with ice cold water, cold sponging and fanning. In the very humid atmospheres around Basrah evaporation was inoperative and immersion in an ice cold bath was sometimes necessary. Obviously

these means were drastic and required careful control by frequent rectal temperatures. Cooling was discontinued as soon as a safe level was reached . . . for instance, 109° was reduced to 104°, or 106° down to 102°. Further reduction might obviously lead to a dangerous collapse. Thereafter further cooling was reserved for any further rise of temperature. Iced enemas and antipyretic drugs should not be used. Venesection, oxygen and circulatory stimulants were often required, whilst quinine has already been mentioned. Intravenous fluids were controlled by estimation of fluid balance, and when the patient recovered consciousness iced drinks and saline were given plentifully. Convalescence often was protracted, and if the patient was not evacuated to a cooler climate it was advisable to test his tolerance to heat by exposure outside the Hospital before returning him to the rigours of the Climate.

In conclusion it is interesting to consider once more that this dangerous climate has been the environment in which civilisation started (for the primitive Indus Valley civilisation grew up in a somewhat similar heat), and that the misty figures of early Genesis, that Abraham, Nebuchadnezzar and Daniel, to say nothing of Sinbad the Sailor and Ali Baba, were all subject to the hazards of the heat, and that perhaps Alexander the Great died in Babylon because there was no Heat Stroke Centre to assuage his fever.

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"PAST HISTORY"

She found a pot of Ergot,
And drained it to the dregs;
A lovely case, the best I've seen—
I cut off both her legs.

(Author unknown)

RETIREMENT OF MISS HELEN DEY

The retirement of our Matron, Miss Helen Dey, is a matter of real regret to the staff of St. Bartholomew's Hospital.

In the first world war she joined the Q.A.I.M.N.S.R. and was one of the first to be sent to France in August, 1914. Pressure of work was heavy, hours were long, but she was always cheerful, giving encouragement to others. A natural energy and vitality sustained a mind with real heart behind it enabling her to give of her best. Her high ideals and devotion to duty were an inspiration to all her colleagues. During the war she was awarded the Royal Red Cross in recognition of her work and was mentioned three times in dispatches. Miss Dey transferred to the regular service and remained a member until 1921. During that time she held many responsible posts. Her work was of a high order and it was clear that she would make her mark and reach a high position in the Nursing profession.

In 1921 Miss Dey was in the U.S.A. working for five years at the Receiving Hospital, Detroit. There the Medical Superintendent paid her very high tribute, stating that they had never had anyone with such outstanding ability. There she was for some time Supervisor of the Out-Patient Department and later Assistant Superintendent of Nurses and was instrumental in bringing about certain improvements in the Hospital. Miss Dey was held in great respect and affection by the many with whom she came in contact, and her charming personality made her a wonderful ambassador.

On her return to England she was appointed Assistant Matron of the General Infirmary at Leeds.

It was in March, 1927, that she took up her appointment as Matron and Superintendent of Nursing at St. Bartholomew's Hospital and it will be agreed by all that it was indeed a lucky day for " Bart.'s " Hers was the distinction of being the first St. Bartholomew's Nurse to be Matron since the formation of its School of Nursing, and she could not have started her responsible work at a more vital time. The State Registration Act for Nurses had only just started to function and the increasing shortage of nurses was causing much anxiety. It might be supposed that the post of Matron at a major hospital would satisfy the ambition of most—but not Miss Dey ; it is true to say that she has been active in all movements which aim at maintaining a high standard of nursing wherever that skill is required.

To give briefly a complete picture of her activities is impossible. Prominent among them are her work as an elected member of the General Nursing Council, and of the Council of the Royal College of Nursing. She is also president of the Association of Hospital Matrons, a member of the Whitley Council for Nurses and Midwives and of the Advisory Committee on Sister Tutors' Courses and Diplomas of the University of London. Other activities include service on the National Advisory Committee of the Ministry of Labour and National Service, on the Advisory Nursing Board of H.M. Prisons, on the Army Nursing Board and on the National Council of Nurses. All this makes no mention of her exacting war work as Sector Matron with its problems of many hospitals in addition to her own. For her work in this capacity she was awarded the C.B.E. in the New Year Honours of 1946.

It is perhaps difficult to realize how great has been her contribution to the profession in achieving so much for the welfare of both nurses and patients. The standard of nursing and the traditions of our Hospital have never been higher in spite of all the difficulties and vicissitudes of the war. Her deep understanding of human nature and

particularly her thoughtful consideration for those in trouble have made her much beloved.

The concluding words of the list of duties of the Matron of St. Bartholomew's Hospital as laid down in 1813, are these .... "*always remembering that as you fulfil your duty, so will you not only become respectable but also highly esteemed.*" We can end with no greater tribute of our affection and respect for her than by saying that she has indeed become "respectable and highly esteemed."

APPOINTMENTS

Miss J. M. Loveridge has been appointed to succeed Miss Dey as Matron to the Hospital.

Dr. Gordon Ostlere has been appointed an Assistant Editor, British Medical Journal.

THE ORDRE OF THE HOSPITAL OF ST. BARTHOLOMEW'S IN WESTSMYTHFIELDE IN LONDON

By G. C. R. MORRIS

THIS is the title of a book, published in 1552, which describes the organisation of the hospital soon after its second foundation. Rahere's foundation lasted from 1123 to the dissolution of the monasteries in 1545, and that of King Henry VIII from 1547 to the National Health Act of 1948; so it may be interesting to recall how the hospital has been governed for the past four centuries.

The Preface explains that in 1547 the hospital possessed only so much "household implements and stuff . . . as sufficed three or four Harlots then lying in child-bed," and the efforts of the citizens of London to restore it were greatly hindered by "the wickedness of report," which had "grown to such rankness" that it threatened both the repute and the work of the hospital — "where in the mean season notwithstanding, there have been healed of the Pocks, Fistulae, filthy Blains and Sores, to the number of eight hundred, and thence safe delivered, that other having need might enter in their room. Beside eight score and twelve that have there forsaken this life, in their intolerable miseries and griefs, which else might have died, and stunk in the eyes and noses of the City." So it seemed good to the Lord Mayor to publish this "Order of the Hospital," that all might judge the adequacy of the arrangements, and perhaps suggest improvements. If, in particular, anyone thought we had more than enough money for "an hundred sore and diseased," the author points out that we are anxious to accommodate as many as one thousand. Finally, he trusts that this account will be a good example to other "Almoisners and Houses of Almoise, known either by the name of hospital, or Savoy."

First, then, there are twelve Governors, appointed by the Lord Mayor, and renewed by the election of half their number every second year. They comprise:—

The President, who is "chief ruler and governor . . . under the Lord Mayor";

The Treasurer, who has all the treasure, rents and benefactions in his charge, and reports to the Governors on October 20 each year; his account book, with the other books and journals, is checked by four Governors acting as Auditors; and he has to present himself for questioning on November 2, when he hands over to the newly elected Treasurer;

Four Surveyors, who have "the view of all the lands and leases pertaining unto this house"; they meet every other Wednesday, and are replaced by two new ones chosen at the Feast of St. Michael;

Four Almoners, who have to come every Monday at least to see that every Officer is doing his duty. "Ye shall also diligently enquire if the Chirurgeons of this house do their duty toward the poor without corruption or partiality, and calling them before you, ye shall enquire what number there were healed that week, and the same deliver, and reward, according to your discretions." They are to admit new patients, to keep an inventory of Utensils, etc., to suggest alterations for the benefit of the poor, and "ye shall also see unto the keeping sweet of the poor, and in your proper persons visit them once every Week at the least, and to see that their service of bread, meat, and drink be truly and faithfully delivered unto them";

Two Scrutiners, whose task it is to enquire for and to record bequests and gifts—"ye shall in every place where you shall have

occasion to come in the company of good, virtuous, and wealthy men, to the uttermost of your power, commend and set forth the good order of this house, and how rightly the goods given to the poor are here bestowed, to the encouragement of other to extend their charity thereunto";

All these are charged "to attend only upon the needful doings of this house, with such a loving and careful diligence, as shall become the faithful Ministers of God, whom ye chiefly in this vocation are appointed to serve," and are offered a Heavenly reward for their labours, typified by the words at the end of the Treasurer's Charge:—"And in recompense of your pains, ye shall be assured of the mercies laid up for you in the promises and blood of Jesu Christ our Saviour."

Next, there are seven kinds of Officer, "continuable or removable, as the governors shall find cause";

The Renter is to collect all rents and hand them to the Treasurer; and to keep four books, each with numbered pages and a Calendar in the front, namely:—a Repertory Book of the Foundation, Charters, Deeds, Leases, etc.; a Book of Survey for alterations in rents and for repairs; a Book of Accounts, for all expenditure and income, and also for a list of patients, their diseases, occupations, cures and deaths; and a Journal, for general matters and the decisions of the Governors (this is the most valuable of the extant hospital records, and has been kept from October, 1549, with only one short gap, to the present day);

The Hospitaller's office "is chiefly and most principally to visit the poor in their extremes and sicknesses, and to minister unto them the most wholesome and necessary doctrine of God's comfortable word, as well by reading and preaching as also by ministering the Sacrament of the Holy Communion at times convenient . . . also whensoever any poor person shall be here presented or sued for, to be admitted into this house, you shall receive the same presentation, calling unto you two of the Chirurgeons of this house, to view and examine the disease of the said person, whether it be curable or not curable." He also has to supervise the distribution of food to the patients, the safe keeping of their valuables, and their discharge when cured;

The Steward and Butler are to provide food as instructed by the Almoners, and attend when it is served to the poor. "Ye shall have to do in none other man's office in this house but only with your own in manner as is above described. But, if ye shall perceive at any time, any thing done by any officer or other person of this house, that shall be unprofitable thereunto, or that may be occasion of any disorder, or shall engender slander to the same: that ye then declare the thing to some one or two of the Governors of this house, and to none other person, nor farther to meddle therein." This admonition, in much the same form, has been repeated ever since after each Officer's charge.

The Matron has to receive the sick from the Hospitaller, and bestow them in the appropriate places. She has charge of the Sisters to see that they do their duty by the poor—in making the beds, keeping the wards clean, and purifying the unclean clothes—and to ensure that they do not leave the women's ward after seven o'clock in the evening (nine in summer). The same Sister is to remain no longer with the same patient than needful cause shall require. When the Sisters are not busy they are to be set to spinning, or some other occupation that will preserve them from idleness and be profitable to the poor, the Matron receiving the flax from the Governors, and returning it, spun, to be sent to the weavers. "Also ye shall suffer no poor person of this house to sit and drink within your house at no time, neither shall ye so send them drink into their wards, that thereby drunkenness might be used and continued among them, but as much as in you shall lie, ye shall exhort them to virtue and temperance, declaring this house to be appointed for the harbour and succour of the dear members of Christ's body, and not of drunkards and unthankful persons";

The Sisters' charge is "in all things to declare and show yourselves gentle, diligent, and obedient to the Matron of this house, who is appointed and authorised to be your chief governess and ruler. Ye shall also faithfully and charitably serve, and help the poor in all their griefs and diseases, as well by keeping them sweet and clean, as in giving them their meats and drinks, after the most honest and comfortable manner. Also ye shall use unto them good and honest talk, such as may comfort and amend them, and utterly to avoid all light, wanton, and foolish words, gestures and manners, using your selves unto them with all sobriety and discretion. And above all things see that ye avoid, abhor and detest scolding, and drunkenness, as most pestilent and filthy vices. Ye shall not haunt or resort to any manner of person out of this house, except

ye be licensed by the Matron, neither shall ye suffer any light person to haunt or use unto you, neither any dishonest person, either man or woman, and so much as in you shall lie, ye shall avoid and shun the conversation and company of all men";

The Porter is to keep the gate; to watch for pilfering, for men going into the women's ward, or women into the men's, and for suspicious people loitering about; to shut the wards at seven; and to punish in the stocks (at the second offence) any patient who is a swearer, or lacks reverence to God, or contemns the Matron, or refuses to go to bed;

The Beadles attend the Governors, and at other times patrol the City for "any person infected with any loathly grief or disease, which shall fortune to lie in any notable place of this City, to the annoyance and infection of the passers by, and slander of this house," and for any discharged patients begging, or shamming disease, and for any sturdy beggar or vagabond; all these they are to warn off or lock up.

"There are also as in a kind by themselves, three Chirurgeons in the wages of the Hospital, giving daily attendance upon the cures of the poor. . . Your charge is faithfully and truly to the uttermost of your knowledge and cunning, to help to cure the griefs and diseases of the poor of this Hospital, setting aside all favour, affection, gain, or lucre"; to take no gift or reward from patients or friends without first informing the Almoners; "also we utterly forbid and command you, that ye by no colour pester or burden this house with any sick or diseased person, for the curing of which person ye before have received a sum or sums of money, upon pain to be dismissed this house."

After the charge of the Visitor of Newgate, there follows a detailed estimate of the hospital's annual expenditure, in which the known charges reach a total of nearly eight hundred pounds, including a salary of twenty pounds for each Chirurgeon, and twopence per person per day for the diets of the poor.

The spiritual needs of the poor are filled by daily services:—"At the hour of eight of the Clock in the morning, and four of the clock at the afternoon, throughout the whole year, there shall a bell be rung the space of half a quarter of an hour, and immediately upon the ceasing of the bell, the poor lying in their beds that cannot arise, and kneeling on their knees, that can arise, in every ward, as their beds stand, they shall by course as many as can read, begin these prayers following. And after that the party whose course it shall be hath begun, all the rest in that ward shall follow and answer upon pain to be dismissed out of the house. And thrice in the week, that is to say, Sunday, Wednesday and Friday, they shall say the litany in manner and form as it is in the end of this book." The details of the services are followed by a long Prayer of Thanksgiving, which has to be learnt by heart and repeated "by the poor that are cured in the Hospital, at the time of their delivery from thence, upon their knees in the Hall before the Hospitaller, and two Masters of this House at the least." The book concludes with a sample of the Passport given to each patient on discharge, together with clothes and money according to his need.

How far the hospital was conducted according to these admirable rules we cannot be quite certain; but the gracious and charitable spirit behind them can be expected to persist in spite of any changes in administration imposed by the Government of the day.

BIBLIOGRAPHY.

A bibliographical note of the book is included in Sir D'Arcy Power's "Selected is a black-letter octavo signed A-I8, printed in London by Richard Grafton, printer to King Edward VI and Deputy Treasurer of the Hospital in 1551. The copy in the Hospital Archives, the acquisition of which was described by Mr. Geoffrey Keynes in this Journal (vol. 44, 1937-8, p. 216), lacks the last three leaves, which contain the Prayer of Thanksgiving, the Passport, and the colophon. Complete copies are to be found in the British Museum (see Sir Norman Moore's "History of St. Bartholomew's Hospital," 1918, vol. 2, p. 164), the Bodleian, the Folger Library in Washington, and the Pepysian Library at Magdalene College, Cambridge.

This edition was reproduced in 1888 by the Early English Text Society in their reprint of Thomas Vicary's "The Anatomie of The Bodie of Man" (appendix xvi, p. 289).

A second edition was printed in 1652 by James Flesher, printer to the City of London, as a small quarto with the title "Orders and Ordinances, for The Better Government of the Hospitall of Bartholomew the Less," signed A-F1, to which two other 16th century pamphlets, on Orphans and on the Customs of London, were attached. The spelling and punctuation of this edition are

altered, and the Daily Services are entirely omitted. The hospital possesses a good copy of this book, which is not so rare as the first. It was reprinted in Strype's edition of Stow (1720, vol. 2, book 6, appendix, p. 51), and twice by W. Morrant Baker—in the St. Bartholomew's Hospital Reports (1884, vol. 20), and as a separate volume in 1885.

CORRESPONDENCE

AN ACT COMPARABLE TO THE GREATER FOLLIES OF HISTORY

To the Editor, St. Bartholomew's Hospital Journal
Dear Sir,

I think the latter part of the February Editorial needs some comment both with regard to the views concerning Medical Education and also concerning the N.H.S.

In connection with Medical Education the writer says, "it is becoming more and more expensive and therefore available to fewer and fewer of his (Mr. Bevan's) future bondsmen." The fact is at the moment all the Medical Schools in the country are more than full and for every student accepted many are being turned down. Naturally I deprecate that economic factors play a great part in deciding whether or not a certain man or woman shall take up medicine. However, this is not preventing the maximum of doctors being trained at the present day as is possible in the available Medical Schools.

The difficulty, however, lies in the shortage of Medical Schools; and I would suggest that many good and big hospitals in London and the provinces are suitable for clinical teaching. What are needed are, on the one hand, experienced teachers both in clinical and preclinical subjects, difficult, though I'm sure, not impossible to procure; and on the other hand, lecture theatres and Anatomy and Physiology buildings (for 2nd M.B. subjects) near the proposed teaching hospitals. Although it affects priorities in the building programme I feel this rearrangement would not substantially alter the number of houses built.

The financial problem of students is quite another question. In future I suggest students thought suitable for a medical education should be given full economic stability during their period of training. The writer's desire for a liberal education obviously should be fulfilled. Is not the present attitude of cramming elementary sciences and so narrowing the general education due to so many prospective students being forced to get scholarships and exhibitions to augment their scanty funds and so be able to study medicine? I refuse to accept the hypothesis that in the future, because medical training is becoming more and more expensive, it is therefore only available for fewer and fewer.

With regard to the emotional attitude expressed on the N.H.S. I assume it was agreed that a health service at some time was necessary. The disagreement is over the type and timing of the N.H.S. Nearly every measure of progressive legislature has been opposed by many on the ground that the timing is not opportune. If we waited for the very best time for such measures we would find that it would never arrive. In the case of the working of the N.H.S. it is unfortunate that the Editorial writer's apparent personal antipathy to Mr. Bevan should stop him from taking even a relatively objective attitude to the N.H.S.

I will cite a few examples of what the N.H.S. has achieved in an essentially practical form, which can be easily assessed, during the first six months of its life.

A. From its inception till November 23rd of the same year, 2,357,000 pairs of spectacles were prescribed to patients. It was estimated that the demand in a year would be from 3 to 4 million. This points to the fact that many people needing spectacles in the past did not obtain them for economic or other reasons. Less than 10 per cent. of them seeing doctors with regard to obtaining spectacles were found not to need them.

B. From July 5th till mid-December, 1948, 1,877,000 dental treatments were completed, 40 per cent. of which were for the provision of dentures. Accurate figures for the pre-N.H.S. period are not available but it appears obvious that very many people were in need of dentures and conservative treatment prior to July and did not get the treatment necessary.

C. Anybody benefiting from Electrical Hearing Aids can now have them and this has obviously improved enormously the happiness and occupational usefulness of many.

Are the supply of Spectacles, Dentures and Hearing Aids to those in need of them, many of whom could not afford them at all and many more could only do so at great personal sacrifice, "a great act of folly"?

Ninety-five per cent. of the population have registered under the N.H.S. They could if they wished not take advantage of the scheme and would only be out of pocket 10d. per week, which is the share allocated to the N.H.S. A considerable section of the 95 per cent. could afford to lose the benefit of the 10d. per week and continue to seek medical and dental advice and treatment privately. Obviously the writer of the Editorial is in a small minority in thinking it a great act of folly.

It is constructive criticism and suggestions of improvement that are necessary both to improve the selection and retaining of doctors and also improve the working of the N.H.S. and not biased and destructive criticism.

Yours faithfully,
J. D. B. ANDREWS.

The Abernethian Room,
St. Bartholomew's Hospital.
February 5th, 1949.

To the Editor, St. Bartholomew's Hospital Journal
Dear Sir,

Your Editorial in the Bart.'s Journal, February, 1949, entitled "Education," very rightly draws attention to the position of the medical student today who is inclined, on account of a crowded curriculum, to regard medicine, first and last, as a

science. Let me say at once that it has been my experience in contacts with many professional men that Bart.'s men have invariably been the best of colleagues, with a sense of the meaning of their vocation.

As a fresher in 1911, with many others our introduction to Bart.'s and medicine took place in the Abernethian room where we were addressed by a member of the senior staff. We were told what it meant to be a Bart.'s man and what would be expected of us when fully equipped and let loose among the public. Does the same thing happen today at Bart.'s? Do other hospitals start their students off on the right foot? Do teachers still stop now and again and remember that inspiration and example is part of their job? The crowding of the clinical canvas, the rush tactics of modern medicine and mass medicine must be leaving little time for thought and poise. The qualified, yet incomplete doctor, then enters a career of hard work and in too many cases ethics, of which he knew very little, fades as time goes on.

In addition to coaching the new student, in order to try and get his mind thinking on the right lines, there should be a lecture or two at some period which deals with history, tradition, codes of honour and ethics in its widest sense. It should not be difficult to insist that all intending medical students should possess a short, interesting and well-written book designed to assist them hereafter. In this way we are more likely to try and work as a team of men and women with loyalty and decency. How well the need for such a brotherhood can be seen at this present moment, when jealousies, scrambling and shouting for position is rife, exaggerated in a large degree by the unhealthy Health Act.

I suggest strongly and very seriously that the *single* reason for the present plight of our past great, old and honourable profession, is due to lack of unity—that division of our ranks is essentially due to lack of moral background. I do not believe that the disgraceful and humiliating daily occurrences, inspired by the politician, would have been tolerated for a moment by an older past generation—men of character who realised their position and worth and were more in touch with tradition and codes of honour. I hope that I and many of my contemporaries will not forget our Bart.'s education and the inspiration of many great teachers, that it will continue to serve us well and that we may try and pass it on to others.

Lord Horder has so rightly remarked that the medical profession is old and lasting and the politician small and transient. To this must be added an understandable ignorance of our complex affairs. Ignorant power has for the moment, and perhaps for a long time to come, defeated a body of professional men who have, in too many places, lacked in moral fibre. Loyalty and understanding in our ranks would make us unassailable from any quarter, however powerful.

If the present young student is going to continue being taught that medicine is only a science, then the day is not far off when there will, without opposition, gradually emerge a whole time salaried, regimented, sapless medical civil service which interpreted means a low standard of medicine.

This gap in the curriculum is obvious and serious and should be filled at the earliest possible moment. Some of the seeds sown must fall on good ground.

Yours faithfully,
W. ETHERINGTON-WILSON.

Cumberland House,
Warren Road, Torquay.
February 9th, 1949.

THE WALES RAHERE SOCIETY

To the Editor, St. Bartholomew's Hospital Journal

Dear Sir,

The Annual Dinner of the "Rahere Society (Wales)," was held at the Park Hotel, Cardiff, on January 25th, 1949. Dr. Colston Williams, the President, was in the chair. There were 60 guests present, the guest of honour being Professor Paterson Ross, Director of the Surgical Unit, St. Bartholomew's Hospital.

The toast of "Bart.'s" was proposed by the President, to which Professor Paterson Ross replied. The toast of the City of Cardiff was proposed by Dr. Ivor Davies and Alderman R. G. Robinson, J.P., Lord Mayor, replied. Mr. Melbourne Thomas proposed the toast of the guests and Professor Gilbert Strachan responded. A most enjoyable evening was spent.

The Rahere Society, Wales, now have three honorary members, Sir Milsom Rees, Dr. C. F. Harris, Dean of Bart.'s, and Professor Paterson Ross. It is hoped to increase the Society to about one hundred members. The officers elected for next year are:—Dr. Frederick Campbell, President; Mr. Melbourne Thomas, Vice-President; Dr. Emrys Harries, Hon. Secretary.

Will all "Bart.'s" men in Wales who have not yet been contacted please communicate with the hon. secretary, The Residence, City Isolation Hospital, Canton, Cardiff.

Yours faithfully,
EMRYS HARRIES.
Hon. Secretary.

City Isolation Hospital,
Canton, Cardiff.
February 12th, 1949.

TENTH DECENNIAL CLUB

To the Editor, St. Bartholomew's Hospital Journal.

Sir,

What has come to the Tenth Decennial Club? I know we were the Orphans of the 1914 Storm and Death; ordinary civil death, was unkind to us in the thirties, but some of us survive with memories of some very pleasant dinners. Are we really too old and too shattered to meet again? Or have my fellow members met and I not heard of it?

Should this meet the eye of other "tens" who still feel young enough to dine, I hope they will write to you and say so. If nothing better came of it they might at least draw a secretarial epitaph.

Yours faithfully,
LINDSEY W. BATTEN.

12 Lyndhurst Road,
Hampstead N.W.3.
10*th January*, 1949.

PATHOLOGY AT BART'S IN THE NINETEENTH CENTURY

By ERNEST H. SHAW, M.R.C.P.

SINCE I am now over eighty years of age, and first entered the service of St. Bartholomews at the age of ten, my memory of the hospital is probably the longest of anyone now living. It has been suggested to me that some of my recollections of distant days may be of interest and should be placed on record.

In 1878 my father was cloak-room attendant, and I helped him with the work of receiving and giving out students' hats and coats. The cloakroom was then next door to the Anatomy Department, and by looking through a key-hole I could see the dissecting room and bodies which I called " skeletons " on the tables. My father deprived me of this fascinating and terrifying spectacle by blocking up the key-hole.

A year later a vacancy occurred in the Library, and I started on my first regular job at the age of 11 years and 2 months.

The Library of those days was a temporary iron building by the old college in Little Britain. Dr. Norman Moore was then the Warden of the College, and I collected the key of the Library from his house.

Mr. Mark Morris was the Steward, and I used to take the illustrated and the other papers to his house by the Little Britain Gate every Saturday and collect them on Monday. For this little service he gave me a new 2/- piece every Christmas. The librarian of that time was Mr. Thomas Godart; he was also a medical artist, and a large number of his paintings are preserved in the Museum, including a series illustrating diseases of the tongue originally made for Mr. Butlin. He also did engravings in wood and stone, the latter being used for illustrations to Mr. Luther Holden's book on Osteology. He left the library about 1882, continued his work in London as a medical artist for five years, and then went to Australia.

I can remember only one member of the clinical staff of those days, Mr. Callender, a big bearded man and stern; I was rather afraid of him. Another large bearded figure of those days whom I recollect clearly was Mr. W. G. Grace. I discovered who he was in after years.

The year 1880 saw the opening of the new building which includes the present library and museum. The ceremony was performed by the Prince and Princess of Wales (afterwards King Edward VII and Queen Alexandra), and my first glimpse of royalty was while standing with other servants at the foot of the main staircase and watching them coming down. Another memorable occasion about this time was a visit to the library by Mr. Luther Holden just after his retirement: all the students present gave him a great reception. He was a lovable man, and I can recall him well—a big cheery man with a white beard and a pleasant smile. The library was the scene of a less commendable episode about 1882, on the day of the Lord Mayor's show. The windows were open and students and guests watched the procession pass. Then the people outside in Smithfield began to chaff the students and of course they replied. The end of it was that the crowd started pelting the students with horse dung. When the windows were closed I helped those inside to clear up the mess.

In 1884 I was transferred to the Museum and this was the beginning for me of the study of pathology, which was to occupy the rest of my life. The Museum was already in its present spacious quarters, and the shelves were fairly well filled with specimens transferred from the old quarters near the Anatomy Department. One of my duties was to collect specimens from the post-mortem room, then situated in a corner beyond the Dispensary between it and the Christ's Hospital wall. I well remember my first visit; it took some time for me to get used to the sights one encountered in such a place. I little thought that in after years I should be making post-mortems myself. After 1886 the specimens were brought to the Museum by a porter. Uniformed porters also carried specimens to the Museum from the operating theatre. On one occasion the tin which contained a large vesical calculus was dropped and the stone fell out on the gravel of the square. The man hunted about, found what he thought was the calculus and delivered it to my room. We thought it looked rather odd and eventually realised that the " calculus " was just a large pebble. The term " box carrier " applied to such porters and was first used of the man who accompanied a surgeon to the ward carrying a box of catheters from which they were selected as required; this, needless to say, was before the days of asepsis.

The head attendant in the Museum when I first went there was named Pickering; he left in 1886 and I succeeded him. The Curator during my first five years was Mr. D'Arcy Power; he was a good-looking man with a fair moustache, always kind and pleasant and I enjoyed working for him. During that time he added about 500 specimens to the collection. The yearly show on October 1st was an impressive one, and my time during August and September was fully occupied in mounting the specimens in jars and numbering them. Macerated bone specimens and plaster casts were included; I learned how to make these casts, and made a large number from various patients in the wards, particularly of limb deformities for M. Walsham, who was in charge of the Orthopedic Department.

Another member of the staff with whom I had a great deal to do was Mr. Anthony Bowlby, who, when Mr. D'Arcy Power succeeded him as Museum Curator, became Surgical Registrar. He gave a weekly demonstration on Friday mornings of morbid anatomical material from the operating theatre and post-mortem room; this I had preserved and took down for him to a classroom in the basement in metal bowls. His visits to my room to look over specimens occurred on most days of the week and often friends or students accompanied him. I used to watch and listen to him, and so began my interest in pathology. I owe a great deal to his teaching. His descriptions were brief, clear and easily followed; the same terseness and accuracy of description characterized his book on surgical pathology. I also helped him with the indexing of notes of cases in the wards, and with compiling the statistical talks for his annual report as Registrar. When he was writing his Jacksonian Prize Essay on diseases and injuries of nerves I even visited former patients in the neighbourhood for him to get after-histories. These were days when if you wanted anything done you had to do it yourself or get anyone who happened to be available to do it, whether it was part of their regular job or not. Many years were to pass before anyone even thought of a Follow-up Department. Another vivid memory of Mr. Bowlby was his going about with a pistol in his hand when acting as Starter at the Annual athletic sports, then held at Stamford Bridge; I was also an official on these occasions, but with the more humble duty of selling programmes. Afterwards Bart.'s acquired its own ground at Winchmore Hill through the efforts of Mr. Bruce Clarke. My recollection of this is limited to one visit in 1906 when I played in a cricket match between the junior staff and servants; at this stage of my career I was Mr. Bruce Clarke's house surgeon.

Mr. Bowlby was also responsible for all histological diagnosis. Sections were cut by students (Surgical Pathological clerks retain some of these duties and were still sometimes known as "cutters" even until 1920) and examined by the Surgical Registrar once a week. Mr. Bowlby was succeeded in this duty by Mr. C. B. Lackwood in 1891, and it was not until 1893 that the hospital appointed its first Pathologist, Kanthack.

My work in the Museum brought me into contact with every member of the active clinical staff, and with some of those who had retired. I remember seeing Sir James Paget during some of his later visits. I used to take Museum specimens down for the lectures of Sir William Savory, and recollect that for the last one he gave, the theatre was packed with students and members of the staff. I was told that it was just an ordinary lecture given in the usual way. He was a fine looking man, very quiet and rather reserved. Later it was my fortune to take a parcel of his treasures to his home in Hanover Square. These were the contents of his drawer in the old museum, where each member of the staff used such a drawer as a locker. The tradition that each member of the clinical staff was entitled to some space of his own, either in the Museum, or much later in the present Pathology Department, where he could keep specimens, continued for another forty years. Visits from Sir Thomas Smith and Mr. Morrant Baker were frequent; their object being to examine specimens which they had removed at operations. Those of Mr. Baker were sometimes epitheliomatous tongues, removed with the aid of an 'Ecraseur," in which he was anxious to see that he had excised the growth sufficiently widely. Most of the staff of those days were tall and striking men, another such was Mr. John Langton, who was interested in herniae and Surgeon to the Truss Society. I remember helping him in the dissecting room with some frozen parts of the pelvic region; when these were frozen hard I sawed through them, so obtaining slabs showing the inguinal canal in different planes. These were hardened in methylated spirit for subsequent examination.

I first recollect Mr. Howard Marsh as a teacher of anatomy in the eighties; when he became Lecturer on Surgery I had to provide his museum specimens, and since he lectured at 9 o'clock very punctually and came to the Museum to select his specimens beforehand, I had to be there in good time. He was gruff but very kind. He afterwards became Lecturer in Surgery at Cambridge University, and Mr. Edgar Willett, then Museum Curator, selected specimens from the "Stock-pot" in my work-room, which I packed and delivered to Mr. Marsh at the railway station on the evening of his departure to Cambridge. I had the same duty to perform some years earlier when Mr. Alfred Willett held this position; in this way quite a number of specimens were supplied for use at Cambridge. It would be interesting to know whether any of them are still there—whether, in fact, a candidate from Bart.'s in the Final Cambridge M.B. may even now sometimes be shown a specimen which originally came from his own hospital.

Mr. Alfred Willett was the donor of the horse, whose skeleton stood on the ground floor of the Museum for many years, (it was removed about 25 years ago). This animal, an old carriage horse from his place in the country, arrived in a horsebox at Cannon St. station one evening, where it was met by Mr. Edgar Willett with several friends and myself. The horse-box was not in a position where it could be unloaded at Cannon St. and the train was reversed and taken into Charing Cross, whence the horse with its escort proceeded to Bart.'s. Here it was taken to the dissecting room, and strung up to the iron star-case leading to the gallery. The first attempt to end its life, made by pouring prussic acid into its mouth, had no apparent effect on the poor beast, and a large amputation knife had to be used to cut its throat. Then began the cutting up, and a mess it was. After removing as much as possible of the soft parts, we took the whole lot up to my room, and put it in the macerating tank. It was new getting well into the early morning hours and I spent the rest of the night in my work-room. Unfortunately the job of preparing and erecting the skeleton was too big for us, and so the whole business had eventually to be handed over to Mr. Marl at the Royal College of Surgeons' Museum.

In the 'eighties it was an interesting sight to watch the carriages of various members of the staff drive into the Square. They were of all kinds, open and closed, and with one or two horses. I remember two in particular, a small, green one-horse carriage belonging to Mr. Butlin, and a large, open carriage and pair used by Dr. Gee. These vehicles waited in a ground behind the "Martha" block. I also remember seeing Mr. Butlin visit the hospital on horse-back. The first member of the staff to use a motor-car was Mr. Lockwood. This was in about 1899. It was an open red car, and I went in it to many of his private operations to cut frozen sections for him. I also performed this service for Mr. Butlin, for whom I had been cutting sections in the ordinary way since the early nineties. It was under his guidance that I first learned to "spot" malignant disease. He was always interested in morbid anatomy, and a frequent visitor to the museum in even earlier days for the purpose of examining his operation specimens; many of these were tongues and growths of the larynx.

For years after I went to the Museum all material for histological section was frozen; the method of paraffin embedding was not introduced until the middle nineties. After hardening in Müller's fluid the piece of tissue was immersed in gum solution, and frozen by means of an ice and salt mixture. I used to fetch the ice from the fishmongers (Sweetings). Sections were cut with a razor mounted on a sliding carrier with three legs, one of which could be lowered by turning the screw at its head. In these days museum specimens were more in spirit. It was after the appointment of Dr. Kanthack as pathologist that formalin came into use for their preservation, and a paper which I wrote with him "The use of Formalin for the Preservation of Museum Specimens" by A. A. Kanthack and E. H. Shaw, read before the Pathological Society of London, November 3rd, 1896, is the first English account of this process.

The present Pathology Department was built in 1908. Where was the pathological work done until then? What is now the Morbid Histology Laboratory was the Physiology Department and Biology was also housed in some of the rooms, destroyed by a bomb in 1940, adjoining the Museum. Pathological work began, of course, in the Museum and its preparation rooms; its main extension was to what is now called the Practical Surgery Room, next to the present Morbid Histology Laboratory. This room was, in fact, for a good many years the Pathology Department. Bacteriological work

began in 1891, when Dr. Klein joined the staff. He was given a room at the top of the Museum block. Various other people had rooms or parts of rooms in this building. Sir Lauder Brunton, for instance, had a laboratory next to the Curator's room in which he pursued the study of pharmaceutical chemistry.

A memory I have of Dr. Kanthack was his examining a nodule on the skin of the face of a student, and finding leprosy bacilli. I remember it so well, for the young man burst into tears when told of the nature of his disease. He was a native of India.

Kanthack was largely instrumental in launching me on the second stage of my career. He was appointed to Cambridge, and in October, 1897, I went there with him as assistant in the University Department of Pathology. Stubbings, who will be known to many Cambridge men of later days, was junior to me. Kanthack died little more than a year later, and left me enough money to help me to start reading medicine. I returned to Bart.'s in 1899 as half-time Museum attendant under Sir Frederick Andrewes, a position which I retained until nearly the time of my qualification at the age of 38 in 1905. During this period all the sections of museum specimens were cut by my niece at my home in New Cross.

I became a house surgeon at Bart.'s, then pathologist, casualty officer and Registrar at the Metropolitan Hospital, and finally pathologist to the Great Northern Hospital, where the rest of my life has been spent. I think I may say that I have enjoyed some reputation for rapid histological diagnosis at operations, and even up to the present time I have used the same type of microtome for cutting frozen sections as that which was used for all purposes when I first did histological work more than sixty years ago.

THE "BART'S" FAIR

It is now possible to give more information about the Fair, which is being organised by the Students' Union to raise funds for the Union.

The Fair will be held in the Medical College Grounds on September 22nd and 23rd and will be open from 11.30 a.m. until 7.30 p.m. on each day ; the opening ceremony being performed at 12.30 p.m. on September 22nd. Permission has been received from the Treasurer and Almoners of the Hospital to use the title of " Bart.'s Fair."

The Medical College Council has generously placed the Charterhouse Site at the disposal of the Students' Union and permission has also been obtained from the Charterhouse Trust for the use of the Cloisters in Charterhouse Square.

All Clubs of the Hospital have been approached to provide some form of entertainment on the central grass plot at Charterhouse Square and it is hoped to provide a continuous programme of entertainment throughout both days of the Fair, with their support.

The Metropolitan Police Band has promised to attend and will provide music during the lunch hour and late afternoon.

M. J. Clarke-Williams has undertaken the organising of an Art Exhibition and all persons interested in contributing are asked to contact him.

The Organising Committee are anxious that the Fair should be a complete success and would like any practical suggestions forwarded to them, as well as individual offers of support from students, upon whom the whole success of this venture depends.

BARTS—GUYS SOCIAL

On Friday, February 11th, a return visit to this hospital was paid by 50 students from Guy's hospital. A conducted tour of the hospital had been organised including a visit to the 1,000,000 volt X-ray machine in the Mozelle-Sassoon Department. A medical demonstration by Dr. Scowen, a surgical demonstration by the professional unit, and a demonstration of radioactivity by Professor Wormall were part of the programme. Tea was served in the Great Hall and later in the evening a twenty-question contest and a general knowledge quiz between teams from the two hospitals took place. Soon after, dinner was served in the refectory and the evening ended with a dance at Charterhouse Square.

It was indeed pleasant to entertain such genial visitors and we trust that the Guy's representatives enjoyed their visit as much as we did their company.

AN UNUSUAL SPACE OCCUPYING INTERCRANIAL LESION

By A. B. HAIGH, M.B., B.S.

THE following case is of interest both as regards the pathology of the lesion, and the slight nature of the symptoms and signs associated with it.

The patient, a farmer aged 60, was admitted to the Neuro-surgical Department on the 5th May, 1948.

History.

The history was that, apart from a blow on the right temporal region 18 years previously, the patient was quite well until 8 months prior to admission. This blow was not followed by unconsciousness or any untoward symptoms. He admitted that he might have received many others while under the influence of alcohol.

However, 8 months before admission he began to notice headaches in the right half of the head and nuchal region. These were throbbing in character lasting anything between half an hour and 2—3 days. They occurred up to three times a week. They seemed to be produced by any slight knock on the head or lying on his right side. They had improved slightly over the 3 weeks immediately prior to admission.

Two months before admission he had first noticed a swelling in the right temporal region which had increased in size at first, but, he thought, had since become smaller.

There were no other symptoms. There had been no vomiting, nor visual impairment and no defect of hearing or speech. He had noticed no paraesthesiae or weakness of his limbs. While the past and family history revealed nothing relevant the patient admitted that he had been accustomed to taking much spirits. He attributed the presence of the swelling on his head to alcohol, and as a result for some weeks had ceased to drink.

On examination, the patient was a very alert and astute old man, though plethoric and overweight.

In the anterior part of the right temporal fossa there was a roughly circular swelling, about 2½ ins. in diameter. The surface was smooth and convex and at its centre was about ½ in. above the surrounding scalp. The edges were ill-defined. It lay beneath the temporal muscle and was entirely non-mobile. There was no pulsation or bruit. Neurological examination was entirely negative. There was slight cardiac hypertrophy and the blood pressure was 210/112. There was no evidence of cardiac failure. The Wassermann reaction was negative.

X-ray.

X-rays of the skull showed a 6 cm. area of bone erosion in the right temporal fossa. The bone in this area was greatly thinned and crossed by a few trabeculations. It was bounded by a margin of dense bone. This was not one smooth curve, but consisted of a series of arcs, linked together with their convexities outward, so as to give a scalloped appearance.

Pre-operative diagnosis.

It was thought that this tumour was an osteoclastoma, a dermoid, or an epidermoid, of the skull. It was considered that exploration of the lesion was indicated.

Operation. 12.5.48.

Under anaesthesia, the tumour became clearly pulsatile, the overlying temporal muscle making it impossible to say whether the pulsation was expansile or transmitted.

The lesion was approached through a right temporal flap; the temporal muscle being separated from the skull by cutting diathermy, and turned down with the scalp.

As this was being done, two parts of the tumour were exposed, where they had eroded the outer table of the skull completely. The anterior of the two was a well-defined cyst about 3 cms. in diameter. The posterior was a low elevation with temporal muscle fibres adherent to it.

The anterior projection of the tumour was aspirated and dark green fluid obtained.

A burr hole was then made in the greatly thinned skull above this portion. The bone here was outer table only, the inner having been completely and extensively eroded to give rise to the scalloped appearance. As the removal of this thinned bone proceeded, it was seen that the two prominences were continuous with a large cystic tumour lying extradurally, on the floor of the middle fossa. The tumour could be separated from the dura by gentle blunt dissection. It measured 7 cms. antero-posteriorly by 7 cms. supero-inferiorly.

The blunt dissection was pursued far medially towards the mid-line. The dura had been depressed to a depth of 5½ cms. from the inner surface of the skull. Futhermore,

A-P view.

Rt. lateral view.

at this deepest point, the dura had been penetrated over an area 3 cms. x 2 cms. and a prolongation of the tumour continued for a further 1½ cms. medially, where it was embedded in the right temporal lobe. The intracranial extent of the tumour, therefore, measured 7 cms. in all three planes. It was removed completely.

The rent in the dura was repaired with temporal fascia, and an attempt made to obliterate the large dead space by suturing the dura to the pericranium. A drain was placed in the space, and the temporal muscle sutured. The scalp was then sutured in two layers after the insertion of a sub-galeal drain. The patient's condition remained excellent throughout the operation.

Post operatively, apart from some initial restlessness, the patient made satisfactory progress and was allowed out of bed on the 5th day. The wound healed perfectly and the decompression was flat and pulsating. He was discharged 2 weeks after the operation.

Examination of the tumour.

The tumour was dull grey in colour with a smooth surface. It was roughly spherical in shape with three elevations; the superficial one, which had emerged anteriorly; the deep intradural projection; and a small posterior one.

The contents consisted firstly, of the dark green fluid, which contained some red cells, and some "degenerated unrecognisable cells." Secondly, the bulk consisted in its semi-solid content which was amorphous, yellow and greasy. This contained 16% of cholesterol and 12% of fatty acids by weight.

The tumour wall was 1.5 mm. thick and consisted mainly of thick fibrous tissue impregnated with haemosiderin. There were also cholesterol crystals surrounded by macrophages and foreign-body giant cells. There were numerous small recent haemorrhages.

Most unfortunately, the lining of the tumour had been destroyed, probably by haemorrhage, and there was no epithelial or neoplastic tissue remaining.

Discussion.

A consideration of the literature leads to the conclusion that this was a case of diploic epidermoid. The behaviour of the lesion was sufficiently typical for the diagnosis to be made even in the absence of exact histological confirmation.

Epidermoids were first described by Cruveilhier in 1829. He called them "Tumeurs Perlées," because their surface had a sheen like mother-of-pearl.

Mahoney[1] analysed 142 cases of verified epidermoid, which, in 1936, was the total in the whole of the literature. He found that 112 were intracranial, 23 were diploic, and 7 intraspinal.

The intracranial tumours arise in the midline anywhere on the base of the brain from the anterior perforated space to the foramen magnum. Their favourite site is beneath the pons and medulla extending out into the cerebello-pontine angle (Bailey[2]).

The rest of the discussion will be restricted to the even rarer diploic type.

King[3] in 1939, described seven cases of epidermoid tumour, three of them diploic. He states that in the latter the x-rays appearances are absolutely typical, and should enable an exact pre-operative diagnosis to be made. These appearances were first described by Cushing[4]. He notes the erosion of the inner table to a greater extent than the outer; with the dense, clearly defined and scalloped border. It is interesting that the case described by Cushing bears an extraordinary similarity to that described here. The bony defect was in an almost identical situation on the left side. The patient had noticed a very small defect in the left parieto-temporal region for 4½ years, this had recently begun to pulsate. For 3 months he had had very slight weakness of the left foot, and nuchal pain. The tumour was 9.0 cms. in diameter and had caused very great compression of the brain in the left temporo-parietal region. There was no erosion of the dura. The existence of the very slight homolateral signs in Cushing's case is of interest, in that it shows a similarity in behaviour to subdural haematomata, which are also slowly growing compressive lesions.

The extensive bony erosion caused by these tumours must be largely due to the pulsation transmitted to them from the brain. In one case described by King, the epidermoid had eroded the orbital roof and opened the ethmoid sinuses.

They also illustrate the slight nature of the signs produced by large, slowly growing compressive lesions as compared with those that infiltrate brain tissue.

Cushing emphasises that the removal must be performed without incising the capsule. If the tumour were opened extensively, complete excision of the capsule would be almost impossible.

The typical pathology of the tumour was described by Bailey. Of their appearance he says—"The surface is smooth, silky, with irregular pea-sized or larger elevations, and peels away readily from the surroundings." The lustrous mother-of-pearl appearance is best seen in the intracranial epidermoids (Cushing).

In the case described here, both the fluid and the semi-solid contents appear to have been quite typical.

Characteristically, the capsule is about 1 mm. thick, and histology shows it to be in three layers. The outer consists of a cellular connective tissue with a few scattered fusiform or stellate fibroblasts.

The middle layer is stratified squamous epithelium 4 to 20 cells thick. The outer cells are flattened and without nuclei. The inner cells are more cuboidal in shape with well preserved nuclei and intracellular bridges. Special staining shows keratohyalin granules.

The inner layer consists of cornified epithelium which is cast off to form the contents of the tumour.

Rowbotham[5] describes two diploic epidermoids, both with characteristic x-ray appearances, and discusses the origin of epidermoid tumours. He mentions two hypotheses. The first is that primitive epidermal ectoderm is included within the skull, when the lateral mass sends in mesodermal elements to separate the embryonic skin from the developing central nervous system. This is the view that is generally held.

The second hypothesis is that primitive neural ectoderm becomes separated from its proper "organisers," and reverts to epidermal ectoderm.

In support of the second theory, Rowbotham states that he examined over a hundred random sections of the skull, and found no epidermal cell rests. But in view of the extreme rarity of these tumours, it would perhaps have been surprising if he had.

Finally, to consider the alternative diagnoses in the case presented; that of traumatic blood cyst is quite untenable, as it is inconceivable that this lesion could have caused such bone or dural erosion or grown to such a massive size. The contents were not those of a traumatic cyst.

Intracranial dermoids do occur, but diploic dermoids are excessively rare. Dermoid cysts almost always contain hair, bone or teeth.

Osteoclastoma of the skull usually only expands the diploe and seldom erodes them. No neoplastic giant-cells were found.

Summary.

A large cranial tumour is described. It is thought to have arisen in the diploe of the skull; and over years, have spread through the cranium, both externally and internally. The complete absense of neurological signs is of interest.

The tumour is considered to be a diploic epidermoid and these lesions are discussed.

The differential diagnosis is also considered.

I am very grateful to Mr. J. E. A. O'Connell, at whose suggestion this paper was written, for his help and encouragement in its preparation.

The photographs of the x-rays were made by the Photographic Department of the Hospital.

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SPORT

R. U. F. C.

January 8th v. Old Rutlishians.
RESULT: Won 10—6.

January 12th v. Reading University
RESULT: Won 27—16.

January 15th v. Aldershot Services.
RESULT: Lost 5—24.

January 26th v. St. George's Hospital
RESULT: Won 39—0.

January 29th v. Old Cranleighans.
RESULT: Won 11—0.

February 2nd v. Fighter Command.
RESULT: Won 17—6.

J. L. C.

February 5th, v. Nuneaton

RESULT: LOST BY 10 POINTS TO 8.

Played on a hard, frosty ground, Bart.'s did well to hold a strong Nuneaton side to a close game. Within five minutes Bart.'s had lost A. M. Baker

(full back) with an injured shoulder and Nuneaton had scored a goal. Thereafter, with Holland deputising at full back, the depleted Bart.'s pack battled nobly against heavy opposition but Nuneaton were always slightly superior at forward. However, Wynne-Jones, at scrum-half, nullified this advantage by effectively "squashing" his opposite number. K. Jones (wing forward) was largely responsible for forcing the Nuneaton fly-half on to the defensive and thus foiled many movements. The defence was good for the most part but a bad lapse in the centre enabled Nuneaton to score one more goal.

Bart.'s scored through K. Jones following up a forward rush, this being converted by Third who also landed a good penalty goal.

2nd Round Inter-Hospital Rugby Cup

February 10th, v. St. Mary's Hospital

RESULT: LOST BY 5 POINTS TO 16.

From the opening few minutes of the game it was obvious that the ruthless superiority of the Mary's three-quarters, enhanced as it was by Sullivan's delightful positioning at full-back, boded ill for Bart.'s

The first half was exasperating to watch. Time and again the Mary's centre broke through a pitiable defence, and but for Moyes and his co-forwards, the score must have been astronomical. One can truthfully say we were fortunate that lemons were taken with a score of only 8—0 in Mary's favour.

Early in the second half the ubiquitous Dick battled his way over the opposition's line and then converted his own try. Our bruised hopes peeped out again; the more so when John flattened the corner post in a most heartening attempt to level the score.

But a penalty under our posts came at quite definitely the wrong moment and after Beatson had made sure of the three points Bart.'s seemed to be a beaten side. Sullivan, by a fine solo run of 50 yards, added another try, which the ever-faithful Beatson again converted.

Murphy made several good runs for Bart.'s, without being able to score, although once or twice he and his supporters had cruel luck.

As it was Mary's won most meritoriously. Bart.'s were not disgraced; there is always another field and another day.

J. D.W.T.

February 12th, v. Middlesex Hospital

RESULT: LOST BY 33 POINTS TO 3.

Coming only 2 days after a gruelling cup match it was a tired Bart.'s side which took the field for this game.

The first half produced some good rugby, especially at forward with the Bart.'s pack holding their opponents and getting a fair share of the ball. However, the backs were weak and could make little of their chances.

After the interval, Middlesex were soon into their stride with their backs running well; they met with little opposition from the Bart.'s back division and scored repeatedly. The forwards hung on to the end but the backs never looked dangerous in defence or attack.

February 23rd, v. Woolwich Garrison

RESULT: WON BY 28 POINTS TO 8.

Bart.'s enjoyed a marked superiority in all departments and had a comfortable win by 2 goals, 1 penalty goal and 5 tries to a goal and a try.

With the pack in a lively mood, Bart.'s were soon in front through a try by Murphy who ended a good movement by running in from 25 yards. Poor handling by the Hospital backs spoilt many promising movements but with the pack well on top, Bart.'s never looked like losing. Moyes hooked well to give the backs plenty of chances from set scrums and in the loose John and Stephens were outstandingly well backed up by Norbury and K. Johns. The three-quarters moved well but the handling was suspect at times. Tries were scored by Stephens (2), John (2), Murphy, Bailey and Norbury; John kicked a penalty goal.

February 26th, v. Oxford University Greyhounds

RESULT: LOST BY 16 POINTS TO 8.

Though beaten by 2 goals and 2 tries (16 points) to 1 goal and 1 try (8 points), Bart.'s played well against a strong Greyhounds side at Oxford.

They started off in earnest and carried the play well into the Greyhounds' half. Receiving the ball from a loose scrum Corbet soon dodged his way through for an unconverted try.

For the rest of the half the Greyhounds were on the attack. Thanks to two beautiful cross-kicks, a breakaway by the scrum-half and good kicking by Duff, they led 13-3 at half-time.

The second half was keenly contested. The home side obtained one more try. From the kick-off a defender dropped the ball. Third, who played very well throughout, pounced on it in a flash: he dribbled and ran 35 yards to score a fine opportunist try. He converted it himself.

A. F. C.

All matches this year were played in anticipation of the Hospitals Cup to be played on February 23rd against Mary's.

We had previously beaten them in November on our ground 4-3 with an under full-strength team. We, therefore, hoped with our additional players to beat the holders and so pave the way to the Final again.

But it was not so to be. The matches this year showed us that we, as a team, had not reached form. Several successes, however, were recorded, notably in beating the Old Cholmeleians 2-1 and drawing with a strong Corinthian-Casuals team 2-2.

Hospital feeling was high as February 23rd arrived. Just previously both our Cup Rugger sides had lost to Mary's. In faith, then, we ordered two coaches to take the team and supporters to our opponents' ground at Teddington.

Our hopes were amply justified for we received voracious support from members of the hospital and nursing staff and also from the Rugger Club. The latter deemed their voices inadequate for this vital occasion and brought all sorts of musical instruments with them to swell the chorus.

And now to the game. We fielded the strongest side we could. Mary's seemed weaker on paper except for their captain, D. Kelleher (Irish international) and G. Sullivan (Welsh Trialist). We opened the attack and soon Grassby sent across a shot at goal which was miss-kicked by their right back into the goal. One up. Soon, however, Mary's replied with a high drop shot from their right wing and we were level again. And so the battle went on, with Bart.'s always slightly on top.

We changed over equal, 1-1. Soon after half-time Mangan beat the Mary's goalkeeper from a

break away but the referee ruled the goal off-side. Mangan was not to be so easily beaten, however, and soon after taking a nice pass from Gilks, on the turn, gave the goalkeeper no chance.

This odd goal lead was maintained until the fatal moment of the game arrived 15 minutes from the end.

Wright, in intercepting a pass from the Mary's right wing, deflected the ball with his arm. He was inside the area. Two Mary's players appealed for a penalty. The referee hesitated, and without confidence gave the decision.

Sullivan made no mistake about it. A No. 9 gave Cox no chance.

The Bart.'s team seemed stunned by this event and never recovered. Kelleher made sure of the issue with a close shot just before time.

It seemed unfortunate that the game should end like this but everyone agreed that it was a most enjoyable tussle.

Before closing mention must be made of the Bart.'s defence which was very sound and particularly Cairns and Batey who masked superbly the activities of Kelleher and Sullivan.

Team: W. H. A. C. Cox; T. S. Cookson, J. A. S. Amos; J. D. Cairns, I. S. Batey, A. N. H. Wright; G. Grassby, T. A. Duffy (Capt.), J. Adams, M. K. Mangan, J. M. L. Gilks.

HOCKEY CLUB

1st Round Inter-Hospitals Hockey Cup
January 29th, v. Middlesex Hospital

RESULT: WON BY 5 GOALS TO 2.

The game opened briskly under dry, fast conditions and our forwards must have put the Middlesex defence off their stroke because Batterham and Khurshid had both scored goals by the time your reporter arrived at Foxbury.

Thereafter the opposition gathered themselves together and made a determined onslaught on our goal keeping the ball well up.

However, our defenders kept their heads and eventually cleared the ball allowing the forwards to break through to the Middlesex goal and force a short corner. We failed to take advantage of this and the Middlesex forwards again took command of the ball. By half-time they had brought the score to 2—1.

In the second half the play remained open and brisk. The standard of hockey, true to cup form, was more vigorous than tactical. On the whole, we were slower in attack than the Middlesex forwards but when in the circle we followed up shots with great success.

On the right wing Godden broke through on more than one occasion spattering the goal posts with hard drives and forcing a succession of corners. Batterham was the chief goal-getter and scored twice more through persistent hard shooting and following-up.

The backs, aided by Hicks's inspired goal-keeping, kept the opposition well in hand allowing them to score only once in the second half and that off a corner. Nehta was especially outstanding amongst all the backs and used his remarkable ball control to great effect.

The halves slaved gallantly and by their ubiquity kept the forwards well supplied while starving the Middlesex of opportunities.

The final score, 5—2, was a fair reflection of the afternoon's play. The side this year is vigorous, containing many new players and should do very well when it has learnt to play with greater cohesion.

J. W. P.

Team: W. Hicks; J. B. Dossetor, N. Nehta; J. Ainley-Walker, A. E. Griffiths, A. Clappen; J. W. Mellows, G. Hirst (Capt.), N. Khurshid, J. Batterham, J. Godden.

RIFLE CLUB

The officers of the rifle club for 1949 are as follows:—

President—Mr. H. J. Burrows; *Vice-Presidents*—Dr. G. Canti, Mr. N. A. Jory, Dr. G. E. C. Francis; *Clinical Hon. Secretary*—D. C. Morgan; *Pre-clinical Hon. Secretary*—B. D. Lascelles; *Hon. Treasurer*—M. C. Hall.

BOOK REVIEWS

SELECTED WRITINGS OF WILLIAM CLOWES, 1544-1604. Edited, with an introduction and notes by F. N. L. Poynter. pp. 179. Harvey & Blythe, Ltd., London, 1948. Price 15s.

Among the many prominent surgeons who have graced the staff of this Hospital, William Clowes should receive primary consideration. Elizabethan surgery was dominated largely by quacks, and the few honest students of the craft who contributed to the development of surgery deserve full recognition. The writings of William Clowes were popular and significant, but few copies have survived to modern times. Mr. Poynter conceived the excellent idea of selecting extracts from Clowes's works contained in the Wellcome Historical Medical Museum, and making them available to a wider public. His book contains an introductory section consisting of a brief outline of Elizabethan surgery, and biographical details of William Clowes; a bibliographical note with information on his writings, and the locations of surviving copies; notes (which are personally preferred at the foot of the page); a biographical index of persons mentioned by Clowes in his text, and a short bibliography.

This book is beautifully produced in a limited edition, includes eight plates (the frontispiece representing a unique portrait of William Clowes), and does ample justice to the text. It is not only a contribution to the history of surgery, but to the history of the Elizabethan period, and does credit to the Editor and the publishers. The association of William Clowes with this Hospital emphasizes the fact that this book should become the personal property of Bart.'s men, particularly if they can appreciate bibliographically well-produced volumes.

J. L. T.

A SYNOPSIS OF PHYSIOLOGY, by A. Rendle Short, C. L. G. Pratt and C. C. N. Vass. 4th Edition, pp. 331 + xv. John Wright & Sons, Ltd., 1948. Price 20s.

The object of this book as laid down in the preface to the first edition is "to give a fairly full summary of modern physiology, particularly human physiology, in a small compass."

In no other book is this aim so nearly achieved, and we have no hesitation in recommending this book to those who, having completed a physiology course, wish to make a rapid survey of the subject.

Ten years have elapsed since the last edition, and this has necessitated the eradication and re-writing of some chapters. Others we recognise as old friends brought suitably up to date.

THE DIAGNOSIS OF THE ACUTE ABDOMEN IN RHYME, by Zeta. H. K. Lewis & Co. Ltd., pp. 93. Price 6s.

Descend, O Muse, and make thy earthly Home in
This little book about th' Acute Abdomen.
See here the Student whose laborious Days
Are damned by massive Textbooks. Look, then praise
The Industry and Charity of "Zeta"
Whose Book is short and sweet and writ in Metre.
The toiling Student, ringed by Solid Facts
Of Path. and Biochem. and even Acts
Of Parliament, now turns with pleased Surprise
To one who can be Funny to be Wise;
Who writes as much as, no more, than he ought;
His Volume, like the Student's time, is short.
The Teacher and the Student know the Trick,
A Jingle helps an awkward Fact to stick,
And linger there beneath Cerebral Laminas
Till brought to Light by Conjoint Board Examiners.
Then, Muse, look forward to the happy time
When all our teachers demonstrate in rhyme
When all the Fire the English tongue affords
Will roll and echo thro' our Halls and Wards.
What oldest Multip. but could hear with awe
Her cysts described in iambic Ease by Shaw?
Even the dullest Student would absorb it
In surgical Spenserian Verse from Corbett.
If Ross should talk in Trochees there's no knowin'
What purple Prosody will come from Scowen.
So give three cheers for Zeta's Metrics
Which yet may lighten the Burden of Surgery, Medicine, Pathology, Special Depts. (Assorted), Children and even possibly Gynaecology and Obstetrics.

DISEASES OF THE EAR, NOSE & THROAT, by D. G. Carruthers, 2nd Edition, pp. 244 + vi. John Wright & Sons, Ltd. 1948. Price 25s.

The need for a satisfactory students' text book of E.N.T. has long been felt and whilst this text is by no means perfect, it probably fills that role better than any other. Emphasis is always on fundamentals and the examination of each part is well written. The section of sinus radiology is worthy of note.

A few criticisms. Penicillin and Calciferol therapy do not receive the prominence due to them —there is no mention of the latter in the section on lupus vulgaris; the caption to Fig 16 informs us that the auditory canal can be straightened by drawing the pinna "downwards and backwards"! The production is of Messrs. Wrights usual high standard.

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